PRIMARY CARE PHYSICIAN ADVISORY COMMITTEE

Meeting Minutes, September 19, 2007

Members in Attendance: Jeffrey Borkan, MD, PhD, PCPAC Chair; Gregory Allen, DO; Francis Basile, Jr., MD; Thomas Bledsoe, MD; Stanley Block, MD; Mark Braun, MD; Denise Coppa, PhD, RNP; Sarah Fessler, MD; Arnold Goldberg, MD; Cynthia Holzer, MD; Victor Lerish, MD; Raymond Maxim, MD; Patrick Sweeney, MD, PhD, MPH. *Associates/Guests*: Rosa Baier, MPH; Steven DeToy; Grant Garcia; Deidre Gifford, MD, MPH; Jim Sattel. *HEALTH*: Valentina Adamova; Jay Buechner, PhD; Dona Goldman, RN, MPH; Peter Simon, MD, MPH; Amy Zimmerman, MPH. *PCPAC Staff*: Carla Lundquist; Mary Anne Miller, RN, MPH, CHES.

Unable to Attend: Munawar Azam, MD; Matthew Burke, MD; Charles Eaton, MD, MS; Fadya El Rayess, MD, MPH; Michael Fine, MD; David Gifford, MD, MPH; Ellen Gurney, MD; Albert Puerini, Jr., MD; Richard Wagner, MD.

Dr. Borkan called the meeting to order at 7:38 AM. Minutes of the June 20, 2007 meeting were approved as written (motion by Dr. Fessler, second by Dr. Coppa, all in favor). Dr. Borkan noted that advisory letters were sent to the Department of Health in response to three of the five CON applications reviewed at the June meeting. The other two applications [Memorial Hospital Radiation Oncology purchase of a linear accelerator and Roger Williams Hospital relocation of the Outpatient Cancer Center] were withdrawn from consideration before the end of June, and were not impacted by the PCPAC discussion. Per Dr. Gifford's request, PCPAC will review CON applications for the January and June submission cycles each year.

Dr. Deidre Gifford, Rosa Baier, and Jay Buechner gave a presentation on public reporting of performance measures for individual physicians, outlining the legislative mandate, the role of Quality Partners of RI, and the goals of the Ambulatory Care Workgroup of the Health Care Quality Program. The initial physician-level ambulatory care measures selected for development are Electronic Medical Record (EMR) implementation, e-prescribing implementation, and physician practice grouping (including descriptive features of practices). Clinical measures were not selected due to the reporting burdens they would place on physicians/practices, as the reporting mandate is not funded for physicians. EMR was chosen due to the wide-ranging interest in its implementation and usage in RI. A draft questionnaire for physicians has been developed, and the Ambulatory Care Workgroup is requesting input from stakeholder groups per HEALTH mandate. All ambulatory providers would be included in the EMR survey/reporting, including sub-specialists and PCPs. Dr. Deidre Gifford remarked that the survey questions include measures of usage and interoperability, but it is important to note that RI is much further along in EMR implementation than the rest of the country.

PCPAC members voiced considerable concern about the selection of EMR as a publicly reported performance measure of individual physicians. Discussion highlights:

- EMR is an enormous financial investment, especially for smaller practices in the current environment for primary care in RI. Small practices feel pushed to make the investment into EMR for very little payback, and with little assurance that the product chosen will have longevity in utility and support. This performance measurement effort will increase pressure on small practices.
- Questions have been raised about the quality of physician/patient interaction when using EMR; notes are described as "cut-and-paste", and physicians may spend too much time keyboarding. Dr. Sweeney observed that in some cases, due to room layout constraints, the physician's back must be turned to the patient in order to put in data. He noted this goes against training and is perceived by patients as poor interaction, despite physician apologies.
- The performance measures that are reported should be more meaningful to the public. Dr. Block remarked that from a consumer perspective EMR it is not necessarily a symbol of good care, and is looked at as potentially compromising for personal data. For a community health center with a patient population that is 40% uninsured, the patients' perspective of quality is having evening and weekend hours, and having staff (or translators) available who speak the patient's language.
- Will this performance monitoring effort provide any targeted incentive or assistance to acquire EMR? Few providers know how to pursue funding or write grants for EMR. A big stumbling block to wider EMR implementation is the multiplicity of systems in use across the health care system, including hospitals, laboratories, radiology, etc. Would entities such as these be willing to invest funds to make their systems truly interconnected, so physicians are not spending additional time inputting lab/test reports into their practice EMR?
- Collecting data on EMR penetration in the state, especially who does not have EMR and why not, is a valuable first step but the structural barriers must be discussed before public reporting by physician.
- It is too early to use EMR as a performance measure for ambulatory care; the evidence is unclear as to the impact of EMR on the quality of care. Reporting of EMR usage as a performance measure would indicate to the public that EMR equals quality. It is a dangerous step to equate the measurement of benchmarks with quality of care.
- Quality is a much bigger issue than the use of a tool such as EMR. The appropriate use of an EMR is necessary but not sufficient to test, measure, and move toward enhanced quality in the practice of primary care. An EMR is needed to

measure quality, but it would be better to present it in the context of other practice requirements, particularly the principles of the patient-centered medical home. These concepts, which are endorsed by ACP and are becoming a national standard, need to be promoted and spread with educational efforts to all providers and to the public.
- Members suggested that use of e-prescribing, or of a patient registry (such as for diabetes), are better markers of quality than EMR usage.
- Concern was expressed that third party payors will use payment pressure to force physicians to perform the data gathering, increasing the physician work burden while reducing payor costs.

The presenters were asked if the survey would be voluntary; Dr. Buechner replied that the decision is not yet made. Eventually this data (or a subset) may be collected in conjunction with licensure. However, licensure is a two-year cycle and there would be no mechanism to update between cycles. Dr. Sweeny noted that the issue of a mandate is critical. If it isn't mandated, a 5% return is typical. An unfunded mandate will be very unpopular; would physician compensation for answering the survey be possible? How will reporting be handled if there is a very low response? Dr. Buechner said another option is to publicly report that a physician did not respond to the survey, which may not be helpful for primary care providers.

Dr. Borkan asked all PCPAC members present (see list above) to vote on six statements:
1. *Collection of data about who has EMR is important.* Vote: All agreed, no abstentions.
2. *Data collection on who has EMR is ready for public reporting.* Vote: All disagreed, no abstentions.
3. *Implementing data collection on EMR as an unfunded mandate is fair to PCPs.* Vote: All disagreed, no abstentions.
4. *The medical home concept is important to reinforce in all measures of primary care.* Vote: All agreed, no abstentions.
5. *The focus on EMR, if it is the only focus, could be a deterrent to quality.* Vote: All agreed, no abstentions.
6. *Lack of EMR equals lack of quality.* Vote: All disagreed, no abstentions.

PCPAC members made the following comments on the survey tool during the meeting and via follow-up email:
- The goals/justification/rationale not stated, nor the scope of public reporting: explain why should this be filled out and what will be shown to the public.
- Length: limit to one page, or go question by question and ask: is this information really essential? Many of the questions seem interesting, but too specific, too much detail and too many - practitioners will not fill them out.
- Graphics: The graphic layout is difficult to follow; the form should be simple to fill out, consult a forms graphic expert.
- Question types: limit to one or two scales
- Question confusion: Some are multiple questions requesting a single answer e.g., "Letters or other reminders directed at patients, regarding indicated or overdue care" (actually two-three categories or questions).
- Answer confusion: e.g., "None the time; no plans" -- this is actually two different answers; what if one is a "yes" and the other is a "no".
- Only data at hand: avoid NPI numbers or other information that must be searched for, checked with another source, or calculated.
- The type of information/reports the survey asks about are the final level of operability for EMRs, and few will have those available this early on.
- If the state does not know who practices with whom, use the questionnaire to get names, not just numbers (question 6).

Dr. Borkan reminded PCPAC members that an alternate for each organization should be appointed; members should make arrangements to notify the alternate if unable to attend a meeting. An agenda plan for 2007-2008 per suggestions made at June meeting and the Director of Health's priorities was reviewed. Several members suggested reviewing medical academies' policy statements on retail-based clinics, and searching for information of insurers policies/favored status toward retail-based clinics prior to the October meeting with MinuteClinic leadership. Two topics were suggested for open months: the primary care needs of the medically uninsured/underinsured, and mental health.

NEXT PCPAC MEETING: WEDNESDAY, OCTOBER 17, 2007

PCPAC is supported by a HRSA Primary Care Services Resource Coordination and Development Grant (Program CFDA 93.130, Grant # U68CS00214) to the RI Department of Health Office of Primary Care. Opinions expressed by PCPAC are solely the responsibility of the committee members and do not necessarily represent the official views of HRSA or the RI Department of Health.